An Evaluation of Domestic Violence Services Provided at a Pediatric Hospital

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ABSTRACT

An Evaluation of Domestic Violence Services Provided at a Pediatric Hospital

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Despite evidence linking domestic violence (DV) exposure with a variety of adverse outcomes, formal programs addressing DV in the pediatric setting are lacking. In order to address DV, St. Christopher's Hospital for Children (SCHC) in Philadelphia, PA developed Children and Mom's Project (CAMP) in 2005. For CAMP, SCHC collaborates with Lutheran Settlement House's Bilingual Domestic Violence Program (BDVP) to screen families for DV and provide such services to those screened positive. This study focused on CAMP's evaluation with the goal to profile the characteristics of DV victims who received DV resources at SCHC, including utilization levels. Data collected between October 2005 and October 2010 on 637 DV victims were retrospectively reviewed and analyzed through descriptive and analytical statistics to assess demographic characteristics, safety markers, and service utilization. Most subjects were female, African American or Hispanic, English-speaking, 18-35 years of age, and reported having one or two dependents. Compared to national statistics of DV victims, our subjects were younger and more likely to be female, African American or Hispanic, single, and with dependents. For each subject, a median of two contacts was made, for a total of 35 minutes of services per day. Subjects who utilized DV services at least thrice, for more than 15 minutes were considered "high utilizers" (31%). Based on two safety variables, "high utilizers" confront more dangerous DV situations than "low utilizers" (<3 contacts, or 15 minutes or less of DV services). Accurate assessments of safety and stability over time were not possible due to inadequacy of the data. Future evaluation of CAMP seeks creation of a survey tool to prospectively assess health and safety outcomes of families receiving DV services.

Statement of the Problem

Evidence for the efficacy of domestic violence (DV) screening in the health care setting is lacking. In fact, the U.S. Preventative Task Force does not currently recommend routine screening for any type of DV in medical facilities due to inconclusive evidence that routine screening lessens the occurrence of DV (U.S. Preventative, 2010). Despite this, the American Academy of Pediatrics (AAP) recommends routine screening for DV in pediatric health care settings (2010). St. Christopher's Hospital for Children (SCHC) in Philadelphia, PA follows the AAP's recommendation by screening for DV and providing DV services through its program, Children and Mom's Project (CAMP). CAMP has had anecdotal success in improving the safety and stability of families affected by DV. In an effort to encourage other medical facilities to adopt similar screening programs for DV, SCHC needs to objectively evaluate outcomes derived from CAMP. This study is one of the beginning stages of the CAMP's evaluation. The goal of the study is to profile the characteristics of DV victims who received DV resources at SCHC, including utilization levels.

Background and Significance

Domestic violence (DV) is more common than many people realize due to the lack of clarity in the definition of DV and the intimacy of the social condition. The American Academy of Pediatrics uses a working definition of domestic violence developed by the CDC as "a pattern of coercive behaviors that may include repeated battering and injury, psychological abuse, sexual assault, progressive social isolation, deprivation, and intimidation…perpetrated by someone who is or was involved in an intimate relationship with the victim" (AAP, 2010, p. 1094; Saltzman, Fanslow, McMahon, & Shelley, 2002). According to the Behavioral Risk Factor Surveillance System of 2005 and National Comorbidity Study-Replication of 2001-2003 (CDC, 2008;

Koenen, Roberts, Stone, & Dunn, 2010), nearly one in four women in the U.S. experience DV within their lifetime. Racial and ethnic minorities, such as Hispanics (OR=1.73), Blacks (OR=1.45), and other people of color (OR=1.7), are at increased risk for exposure to DV compared to Whites (Koenen, et al., 2010).

Childhood exposure to DV is common in the U.S. Specifically, 59% of DV victims live in households with children (McDonald, Jouriles, Ramisetty-Mikler, Caetano, & Green, 2006). According to the most recent study, 15.5 million children are exposed to DV (McDonald, et al., 2006). These children are at risk for numerous mental and physical health consequences including depression, anxiety, post-traumatic stress disorder, poor academic performance, behavioral problems, risk-taking behaviors, and child abuse (Bair-Merritt, Blackstone, & Feudtner, 2006; Mrug & Windle, 2010). As adults, childhood DV exposure may contribute to the development of depression, obesity, smoking, and coronary artery disease (CDC, 2010).

Intimately related to childhood DV exposure is the issue of child abuse. In one study, child abuse was 4.9 times more likely in families with DV than in families without DV (Rumm, Cummings, Krauss, Bell, & Rivara, 2000). In 2007, there were 3.2 million referrals to child protection service agencies in the U.S. for suspected cases child abuse or neglect. (U.S. Department of Health and Human Services, 2009). As a result of child abuse, 1,760 children die in the U.S. annually (U.S. Department of Health and Human Services, 2009). For those who survive, child abuse may result in depression, behavioral problems, poor academic performance, and a number of adverse physical health outcomes, including contusions, lacerations, and fractures. The most severe cases of child abuse may result in seizures, spasticity, blindness, paralysis, and mental retardation. (Adamsbaum, Grabar, Mejean, & Rey-Salmon, 2010; Jayawant & Parr, 2007).

DV and child abuse have a significant economic impact. According to Chan and Cho's review of studies on the costs of DV (2010), productivity loss from DV in the U.S. is estimated at $13.7 billion per year, accounting for absenteeism, tardiness, and distraction (Reeves & O'Leary-Kelly, 2007). In addition, adults with a history of child abuse victimization have worse economic means than those who have never been victims of child abuse (Currie & Spatz Widom, 2010). They also have lower educational attainment, IQ scores, and probability of having a skilled job (Currie & Spatz Widom, 2010). Considering that one million confirmed cases of child abuse occur per year (Currie & Spatz Widom, 2010), the effect on the economy is profound. Altogether, DV and child abuse have resulted in enormous economic costs due to decreased adult productivity.

Health care facilities have reason to adopt their own DV screening and outreach programs. Chan and Cho (2010) reviewed several studies on the cost analyses of DV. According to the studies, they estimate that the direct medical costs of DV in the U.S., based on the bottom-up model, range from $2.6 to 7 billion every year (Chan & Cho, 2010). The bottom-up model calculates the unit cost for each type of resource utilized based on the measurement of all resources utilized by individuals (Chan & Cho, 2010). Likewise, direct mental health costs of DV in the U.S. ranged from $1.44 to 6.8 billion (Chan & Cho, 2010). Moreover, the short-term medical costs of child abuse range from $41.6 million to $9.5 billion (Corso & Fertig, 2010). This includes utilization of health and mental health care, such as inpatient services, outpatient services, and medication (Corso & Fertig, 2010). In 2007, the long-term medical costs of child abuse from chronic illnesses, such as depression, drug/alcohol abuse, and obesity, totaled between $67.9 million to $10.9 billion (Corso & Fertig, 2010). Therefore, preventing DV and

child abuse may have a tremendous impact on the lives of children, health care utilization, and society at large.

Prevention of child abuse can be extremely difficult, and reliance on Child Protective Services (CPS) to address child abuse may not be sufficient. A recent study found that families investigated by CPS for suspected cases of child abuse or neglect had no less risk factors for DV a year later than those families not investigated by CPS (Bakalar, 2010). Risk factors for child abuse included low social support, low family functioning, poverty, low level of education and/or depression of the caregiver, and anxiety, depression, and/or aggressive behavior of the child (Bakalar, 2010). Given the high co-occurrence of DV and child abuse, one mechanism by which the latter may be prevented is through the reduction of the former.

These findings have led the American Academy of Pediatrics (AAP) to recommend that pediatricians routinely screen caregivers for DV (2010). The AAP also suggests that pediatric residency programs integrate DV training into their curricula (AAP, 2010). This form of screening is described as "one of the most effective means of preventing child abuse" (AAP, 2010, p. 1094). Yet, very few pediatricians routinely screen for DV. According to the most recent studies, merely 5-21% of pediatricians screen for DV on a regular basis (Bair-Merritt, Giardino, Turner, Ganetsky, & Christian, 2004; Erickson, Hill, & Siegel, 2001). In addition, DV training is not a regular part of medical residency training. Almost 74% of pediatricians in practice have never been trained on DV during residency (Bair-Merritt, et al., 2004; Erickson, et al., 2001). Similarly, there is no current residency training accreditation requirement on child abuse and neglect (Christian, 2008).

In particular, Philadelphia, PA markedly needs routine DV screening and services. In 2009, there were 114,379 confirmed DV calls to the Philadelphia Police Department

(Philadelphia Police, 2009). As a result, 4,927 arrests were made and 36 victims died that same year (Philadelphia Police, 2009). Worse yet, these rates are increasing. Between 2008 and 2009, there was a 67% increase in reported DV homicides in Philadelphia (Urbina, 2009). Sadly, there are too few resources in response to statistics. For example, there is only one DV emergency shelter in Philadelphia, with a total of 100 beds, including cribs (Women, 2010). Considering that 9,599 calls were received by the Philadelphia Domestic Violence Hotline in 2009, it is not surprising that as many as 4,000 women and children are turned away from this DV shelter each year (Philadelphia Police, 2009).

In response to the AAP's recommendations and the DV statistics reported for Philadelphia, St. Christopher's Hospital for Children (SCHC) has initiated Children and Mom's Project (CAMP). CAMP is a DV screening and intervention program designed to identify and intervene on behalf of families affected by DV (McColgan, Cruz, McKee, Dempsey, Davis, Barry, et al., 2010). The program has several components and involves a partnership with Lutheran Settlement House (LSH)'s Bilingual Domestic Violence Program (BDVP) of Philadelphia (McColgan, et al., 2010). As part of this partnership, a DV counselor employed by LSH's BDVP works collaboratively with SCHC health care professionals on-site to provide DV services aimed to improve the safety and stability in the lives of DV-affected families. These DV services include supportive and crisis counseling, safety planning, legal referrals and mental health referrals, emergency shelter placement, victim's compensation assistance, advocacy, court accompaniment, and education on the impact of DV exposure on child behavior. In addition to providing services for DV victims, the onsite DV counselor assists in developing protocols for managing DV and trains SCHC staff on DV and workplace violence. At SCHC, every pediatric resident, nurse, and new hospital staff member receives training in DV (McColgan, et al., 2010).

In return, SCHC provides an office, computer, telephone, and other basic resources for the on-site DV counselor. CAMP makes SCHC one of two pediatric facilities in the U.S. with a full-time, on-site DV counselor (personal communication, Mario Cruz, December 10, 2010; O'Campo, Kirst, Tsamis, Chambers, & Ahmad, 2011).

SCHC also effectively targets those at highest risk for DV. For example, female caregivers are typically the ones at SCHC who take care of the health needs of their children (McColgan, et al., 2010). The neighborhood surrounding SCHC has high rates of violent crime. In 2006, there were about 13,000 incidents of DV in the four zip codes surrounding SCHC (19134, 19124, 19140, and 19133), which accounted for 20% of all DV-related crime in Philadelphia (Philadelphia Neighborhood, 2008). In addition, the majority of SCHC patients are racial minorities. In fact, 60% are Hispanic (half of whom speak only Spanish), 30% are African American, and 10% are of other racial groups (McColgan, et al., 2010).

This has allowed SCHC to reach many victims of DV. Since 2005, SCHC has identified and intervened on behalf of 686 families affected by DV. Although SCHC has experienced anecdotal improvements in the safety, stability, and overall well-being of DV-exposed families, it needs a more objective assessment of the program's efficacy. If SCHC can demonstrate that DV services can effectively improve physical and mental health, then a case could be made to promote the establishment of similar DV services nationwide.

Contributions of Study and Specific Aims

This study was a retrospective cohort study of the DV counselor's charts. The first objective was to profile the characteristics of DV victims who received DV resources at SCHC. We wanted to know if DV victims served by CAMP are demographically different than those identified across the U.S. The second objective was to determine the association between DV

service utilization and changes in safety and stability over time. DV service utilization included frequency of contacts, longitudinal involvement in CAMP, duration of DV services, and types of DV services. We hypothesized that longitudinal use of services leads to increased levels of safety and stability.

Specific Aims:

- Compare the demographic characteristics of DV victims identified by CAMP to the demographic characteristics of DV victims identified across the U.S.
- Describe the utilization of DV services by DV victims in CAMP
- Assess changes in safety and stability of the DV victims over time

Research Design and Methods

Overview of the Study Design

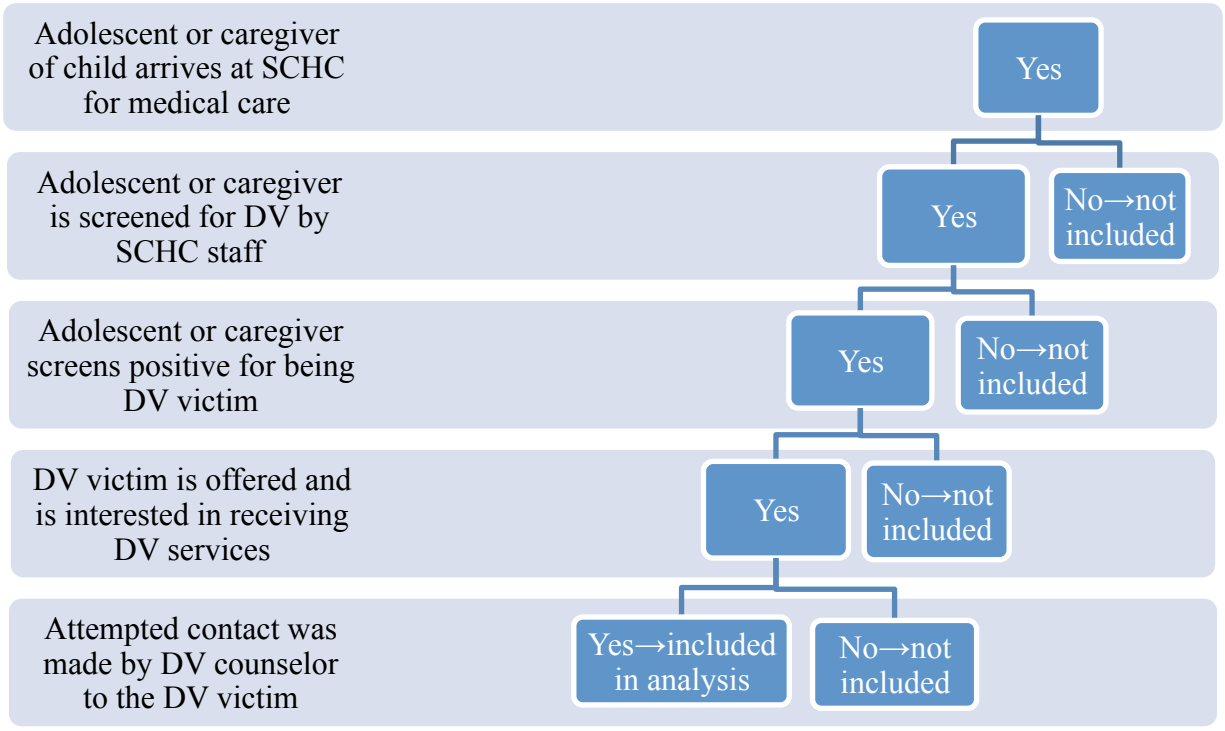
The research team retrospectively reviewed de-identified data from charts of approximately 637 former DV victims of LSH's BDVP who were positively screened for DV and sought DV services at SCHC between October 2005 and October 2010. It is worth noting that these charts are not related to the medical records of patients, and, thus, personal health information (PHI) was not examined or collected for this study. The research team consisted of Dr. Augusta Villanueva, Dr. Mario Cruz, Patti Barry Cruz, and Christine Weirich. The goal of this review was to profile the characteristics of DV victims who received DV resources at SCHC, including scope of utilization levels. SCHC staff did not routinely screen for DV before 2005.

Subjects

The subjects of this study fulfilled all of the following criteria: 1) were either adolescent patients or caregivers of patients at SCHC, 2) were screened for DV by SCHC staff, 3) disclosed to SCHC staff that they were DV victims, and 4) expressed interest in receiving DV services

from the program's DV counselor (see Figure 1). The study included charts from qualified subjects who participated in CAMP between October 2005 and October 2010. CAMP focuses its DV services on those living within the Philadelphia County due to its location. The study excluded subjects under the age of 14, since CAMP does not provide DV services for young children. In addition, the study excluded charts of DV victims who were not identified by CAMP. The study did not exclude any charts based on race, ethnicity, gender, age, sexuality, or religion. Figure 1 below, describes the necessary criteria for inclusion of subjects in the study.

Figure 1. Selection Process of Subjects



Variable Definition and Measurement

For the purpose of this study, we analyzed only variables that contributed to the study's aims. Information previously extracted from extant charts included demographic characteristics, services rendered to each subject over a specific time frame, and markers of safety and stability.

The demographic profiles document which populations at SCHC are receiving DV services from CAMP. Demographic data were categorized into age (in years), race, gender, marital status, employment status, housing status, educational attainment, preferred language spoken (English, Spanish, and/or other), source of income, and number of dependents. These demographic data describe the population of DV victims identified at SCHC, and were used to compare the population of DV victims identified at SCHC with those identified across the U.S.

Variables related to utilized services include dates of first and last contact, time spent on each contact, location of each contact (in person at SCHC, over the phone, or in person at another location), person involved in the contact (DV victim, health or social services professional, or family member/friend of DV victim), and types of services rendered (e.g. supportive and crisis counseling, safety planning, legal and mental health referrals, emergency shelter placement, victim's compensation assistance, advocacy, court accompaniment, and education on the impact of DV exposure on child behavior). The dates of first and last contact helped to identify the duration of involvement with LSH's BDVP. Additionally, the time spent on each contact and type of contact allowed a characterization of utilized DV services.

Markers of safety and stability were collected to identify changes that may have occurred in response to the utilization of DV services. Changes in safety were documented through the permission of a DV counselor to call the DV victim, to safely leave a voice message with the victim, and the need to speak with discretion when leaving a phone message with another person. Markers of stability for the victim include changes in employment status, housing status, marital status, educational attainment, income source, and number of dependents. Implicit in cases involving a change in marital status is a higher level of legal services received regarding the divorce process. Changes in housing status may be used as a marker of economic stability.

Educational attainment and employment status are markers for potential wage earning and career success. The number of dependents is important as the burden of child rearing can be great and may affect the ability of DV victims to attend DV services due to time and logistical constraints.

Analysis Plan

We used Statistical Package for Social Sciences (SPSS) and Microsoft Excel to answer the three research questions of this study. The first question regards the demographic characteristics of DV victims utilizing DV services. Descriptive statistics, such as mean, median, mode, standard deviation, range, and percentage were used to describe the demographic characteristics. The second question regards the DV service utilization of DV victims. This includes longitudinal involvement (total days), duration of involvement (total minutes), frequency of involvement (total number of contacts), use of the phone and/or in-person contact, people involved in the contact, and location of services. These variables were measured by mean, median, mode, standard deviation, range, and percentage. It was not possible to answer the third question due to inadequacy of the data. Instead, the most recent safety and stability markers were described through percentages. We then compared the high utilizers (subjects who utilized at least 3 contacts and over 15 minutes of services) with low utilizers (all other subjects). To compare demographic characteristics, service utilization, and safety markers, we used chi-square tests, unpaired t-tests, and Mann-Whitney U tests.

Human Subjects Consideration

Drexel University's Institutional Review Board granted approval of this study in 2011. This study involved a retrospective chart review and the research team did not make contact with the subjects. Personal health information (PHI) was not viewed or used (see Appendix). The following information was not included in the database: name, date of birth, phone numbers,

home address, email address, social security numbers, emergency contact information, and emergency custody contact information, or victim identification number. The file linking the victim identification numbers to the study's code numbers for each subject was stored with the original database on password-protected computers in locked offices of LSH. The data for this study was previously de-identified by LSH staff. Thus, the study's protocol did not place its subjects at more than minimal risk. The research team guarded against confidentiality breaches by storing all data pertaining to the study, which were previously de-identified, in a password-protected file of a flash drive. Adverse outcomes were highly unlikely to occur. Furthermore, the benefits derived from this study appear to outweigh any potential risks to its subjects. DV victims that seek CAMP services in the future at SCHC may potentially benefit from expanded services tailored to their needs.

Results

The results of this study are reflective of the entries of 2,711 contacts for 637 subjects who participated in CAMP with at least one contact involving CAMP staff between October 1, 2005 and October 1, 2010. Data pertaining to 49 DV victims collected between July 14, 2010 and September 29, 2010 were not included in the study. During this time, there was a change in DV counselors at SCHC. Entries of the data pertaining to these 49 DV victims were left out due to the manner in which these were organized by a counselor, followed by their retrieval from the database.

Demographic Characteristics of Subjects

The following are the demographic characteristics of all subjects who utilized DV services at least once between October 1, 2005 and October 1, 2010 (see Table 1). The overwhelming majority of DV victims served by CAMP were female (99.2%). Of DV victims

who had at least one contact with CAMP, 39% were Hispanic, 38.8% were African American, 15.4% were Caucasian, and 6.8% were of other races. Although many of the subjects were Hispanic, only 7% of subjects used Spanish as their primary language. Most subjects used English (91.4%) as their primary language, and a small minority used other languages (1.5%). Marital status was undocumented for 322 of the 637 subjects. Of those with a known marital status, 45.7% were single, 29.2% were in a dating relationship, 21% were married, 3.9% were separated, and 0.3% were divorced. Subjects varied in age, from 14 to 65 years old. The mean age of subjects was 29.7 years old with a standard deviation of 9.6 years. The median was 28.2 years of age and mode was 25.6 years of age. Approximately 74.4% of subjects were between the ages of 18 and 35. The mean number of dependents of the subjects was 2.1 with a standard deviation of 1.7. The reported median was 2 dependents, and reported mode was 1 dependent. About 78.3% of subjects reported having between one and three dependents. The response rates for each variable used are as follows: gender 100%, language 93.7%, number of dependents 70.8%, race 64.4%, marital status 49.5%, and age 41%. The following variables were not included because these had a response rate of 6% or less: employment status, educational level, source of income, and housing status. The following table compares the demographic characteristics of DV victims in CAMP to those identified across the U.S. and to the general U.S. population. In general, DV victims in CAMP were younger and more likely to be female, Hispanic or African American, English-speaking, single or dating, and with dependents.

Table 1. Demographic Characteristics of Subjects Compared to DV Victims in the U.S. and the General U.S. Population

Characteristics	Number of Subjects in Study	% of Subjects in Study	% DV victims in the US[1]	% General Population in the US[2]
Gender	637	100		(N=281,421,906)
Female	632	99.2	86	50.9%
Age in years	261	41		
<18	9	3.4	2.7	25.7
18-25	100	38.4	26.1	10.9
26-35	94	36	34.9	14.4
36-55	54	20.7	34	29.9
56-65	4	1.5	2.3	8.3
Race	410	64.4		
African American	159	38.8	26.4	12.9
Caucasian	63	15.4	37.1	75.1
Hispanic[3]	160	39	33.6	12.5
Other	28	6.8	2.8	12.6
Language	597	93.7		
English	546	91.4	--	86.2
Spanish	42	7	--	7.5
Other	9	1.5	--	6.3
Marital Status	315	49.5		
Single	144	45.7	9.6	30.8
Dating	92	29.2	--	--
Married	66	21	2	50.3
Separated	12	3.9	71.1	2.2
Divorced	1	0.3	17.3	10.4
Number of Dependents	451	70.8		
0	29	6.4	58.3	--
1	183	40.6	--	--
2	109	24.2	--	--
3	61	13.5	--	--
4	36	8	--	--
5+	33	7.2	--	--

[1]Based on Bureau of Justice Statistics, 2011 and Smith & Farole, 2009, [2]Based on the 2000 US Census Bureau, [3]Considered ethnicity, not race, on US Census

Within the total population of subjects, we separated those who frequently utilized DV services (high utilizers), and compared them to the rest of the subjects (low utilizers). High utilizers are defined as those subjects who received more than 15 minutes of DV services, and who were involved in at least 3 contacts with CAMP staff. There was a total of 195 subjects who fit this description, representing 30.6% of the total population of subjects. The demographic characteristics for high utilizers were similar to those of low utilizers. There were no statistically significant differences in gender ($p=0.57$), race ($p=0.77$), preferred language ($p=0.31$), age ($p=0.96$), number of dependents ($p=0.85$), and marital status ($p=0.23$).

Safety of DV Victims

To assess the safety of subjects' DV situations, we reviewed the records left by CAMP staff on protocols for making phone calls to the subjects. For example, if a subject requested to not be called due to safety measures, this request was recorded, and CAMP staff did not initiate phone calls to the subject. Only the most recent documentation of the DV victims' situations could be analyzed. Thus, changes in safety could not be assessed. For 14% of all subjects, the CAMP staff needed to use discretion when contacting the subject over the phone. For 8% of all subjects, it was unsafe for the CAMP staff to leave phone messages. For 6.4% of all subjects, it was unsafe for the CAMP staff to initiate any phone call with the subject. In this manner, safety protocols were documented for all DV victims, creating a 100% response rate for the three noted variables.

The DV profiles of high utilizers were generally more dangerous than that of low utilizers. For 23.1% of high utilizers, the CAMP staff needed to use discretion when contacting the subject over the phone. The percentage for this variable was greater than that of low utilizers by a chi-square of 19.4 ($p<0.001$). For 13.3% of high utilizers, it was unsafe for the CAMP staff

to leave phone messages. The percentage for this variable was greater than the percentage for low utilizers by a chi-square of 10.8 (p=0.001). For 6.7% of high utilizers, it was unsafe for the CAMP staff to initiate any phone call with the subject. In the context of examining this variable, there was no statistically significant difference between high utilizers and low utilizers (chi-square=0.025, p=0.875).

Utilization of DV services

The utilization of DV services included overall length of time spent with CAMP (in days), total length of services (in minutes), frequency of DV service utilization (i.e. total number of contacts made with CAMP), use of the phone and/or in-person contact, location of services, and people involved in the contact. Table 2, below, describes the amount of time utilized by the CAMP staff to provide DV services to each client. The variables measured included the longitudinal involvement (total days), duration of services (total minutes), and frequency of involvement (total number of contacts). All three variables were strongly skewed to the left. There were 17 subjects who utilized 0 minutes and who could not be contacted.

Table 2. Time Utilized by CAMP Staff to Provide DV Services to All Subjects (N^1=637)

	Minimum	Maximum	Mean	Median	Mode	SD^2
Longitudinal involvement (total days)	1	1289	55.8	1	1	174.2
Duration of services (total minutes)	0	7720	112.3	35	30	404.2
Frequency of involvement (total numbers of contacts	1	218	4.2	2	1	13.2

[1]N=number of responses, [2]SD=standard deviation

The initial contact with the DV counselor took place in person at SCHC in 64.5% of the cases, over the phone in 33.6% of cases, and in person at other locations in 1.9% of cases. Most contacts with the DV counselor directly involved the DV victim (95.2%). Those contacts which did not directly involve the subject included other professionals (2.2%), family or friends of the DV victim (3%), and others (1%).

Subjects who were frequent users of DV services differed significantly in CAMP service utilization from the total population of subjects. Table 3, below, contains the longitudinal involvement (total days), duration of involvement (total minutes), and frequency of involvement (total number of contacts) of high utilizers. There were statistically significant differences in CAMP service utilization between the high utilizers and the low utilizers for all three variables ($p<0.001$ for all three).

Table 3. Time Utilized by CAMP Staff to Provide DV Services to High Utilizers (N^1=195)

	Minimum	Maximum	Mean	Median	Mode	SD[2]
Longitudinal involvement (total days)	1	1289	166.3	30	8	280.9
Duration of services (total minutes)	20	7720	288.8	115	20	698.3
Frequency of involvement (total numbers of contacts	3	218	10.9	5	3	22.5

[1]N=number of responses, [2]SD=standard deviation

Discussion

Our review of the records of DV victims who participated SCHC's CAMP between October 1, 2005 and October, 1, 2010 describe the demographic characteristics of DV victims, their most recent safety situation, and their utilization of DV services. Most subjects were female, African American or Hispanic, English-speaking, 18-35 years of age, and reported

having one or two dependents. Compared to national statistics of DV victims, our subjects were younger and more likely to be female, African American or Hispanic, single, and reported having dependents. For each subject, a median of two contacts was made, for a total of 35 minutes of services per day. Subjects who utilized DV services at least thrice, for more than 15 minutes were considered "high utilizers" (31%). Based on two safety variables, "high utilizers" confront more dangerous DV situations than "low utilizers" (<3 contacts, or 15 minutes or less of DV services). Accurate assessments of safety and stability over time were not possible due to inadequacy of the data.

The demographic characteristics of DV victims served by CAMP are different than those of DV victims across the U.S. as well. Many of these demographic characteristics are easily explained by the source through which subjects were identified. CAMP's DV victims were slightly younger, more likely to be female, and more likely to have dependents than DV victims identified across the U.S. It is likely that most DV victims identified at SCHC are young parents with children under the age of 18 who are medically served by SCHC. In addition, it is more common for female caregivers than male caregivers to tend to the health needs of their children. There were many less Caucasians, many more African Americans, and slightly more Hispanics involved in CAMP than DV victims who were identified nationally. This may simply reflect the demographic factors linked to the neighborhoods surrounding SCHC. The great majority of residents in these neighborhoods are African American or Hispanic. In fact, 60% of patients at SCHC are Hispanic, 30% are African American, and 10% are of other racial groups (McColgan, et al., 2010). This differs greatly from the national rates of race, which are 75.1% Caucasian, 12.9% African American, and 12.5% Hispanic. The demographic results of this study, in comparison to national statistics, exemplify its limited generalizability.

Unlike the other demographic characteristics, the differences in marital status between our data and the national data were not as easily explained. For marital status, when "single" and "dating" are combined to match the national data, we find that there are almost eight times more single DV victims in CAMP than those identified in the U.S. At first, this is surprising, since most of the DV victims were identified after bringing their children to SCHC for medical care. This may be indicative of a high number of single-parent families served by SCHC. If so, it shows that screening needs to include mothers who live alone. Another theory lies in the manner in which DV is identified. The number of DV victims across the country is based on police reports of physical or sexual assault. Thus, a large number of DV situations reflect a case of under-reporting (Klein, 2009). In addition, CAMP includes emotional and financial abuse in its definition of DV. Since the national statistics are based on the most severe DV cases, the relationships of these identified DV victims are more likely to have emerged from separation or divorce when escaping the escalating DV than those with less severe DV situations. Thirdly, the differentiation between single status and dating status may be unclear. In a dating relationship, one partner may state he/she is 'single' if angry at the other partner, but admit to 'dating' if content with the relationship. Lastly, referrals are based on a *history* of abuse. Thus, a DV victim may be single and currently safe with a past of abuse.

In reviewing the data, two groups emerged: a group that highly utilized DV services ("high utilizers") and a group that rarely utilized DV services ("low utilizers"). Given that many of the subjects infrequently utilized DV services, the data on DV service utilization is strongly skewed to the left. In separating the high utilizers from low utilizers, the researchers sought to examine whether there were differences in demographic characteristics between the two groups. If differences existed, this information could help the CAMP staff to improve the services they

provide to the population of subjects who infrequently utilize services. The high utilizers and low utilizers differed in the amount of DV service utilization, and with regard to two safety variables but not in demographic characteristics. Only 30.6% of subjects utilized DV services at least 3 times and for more than 15 minutes. This suggests that 69.4% of subjects did not use services longitudinally. In fact, most subjects referred to the DV counselor had only one contact with CAMP staff. Lastly, high utilizers dealt with more dangerous DV situations than low utilizers. We speculate that DV victims in dangerous situations are more likely to need longitudinal support than DV victims in non-dangerous situations. This would also suggest that those at highest risk are seeking the services they need.

There are several theories as to why so many DV victims do not seek services longitudinally. One theory is that many identified DV victims are not ready to seek help yet. The decision to leave a DV situation can be viewed in the context of a behavioral change. The Transtheoretical Model explains that there are six stages to behavioral change: precontemplation, contemplation, preparation, action, maintenance, and termination (Prochaska, Redding, & Evers, 2008). Many DV victims may be in one of the first three stages, and, thus, may not be ready to seek help. The current DV counselor of CAMP has observed that many DV victims referred to her are in the precontemplation stage (unhappy with the relationship but unaware of the danger of the abuse) or contemplation stage (want to leave to leave but are not ready). This became particularly noticeable to the DV counselor when comparing DV victims helped at SCHC, which actively seeks DV victims, to those helped at LSH, which passively seeks DV victims. Moreover, the stage of maintenance is particularly difficult for DV victims: Most women return to their abusers seven times before leaving them permanently (Family, 2004). This may be due to barriers in receiving DV services and the cycle of violence. Some examples of barriers include

lack of resources, institutional responses, and traditional ideology (Women, 2010). The cycle of violence has three stages. The honeymoon stage is one in which the abuser acts abnormally kind towards the victim and promises to change. During the honeymoon stage, DV victims are more likely to stay in the relationship, because they think that the abuse has ended. However, this is often followed by a tension building stage and an increasingly violent incident (Minnesota, 2008). The current DV counselor has observed that when a DV victim is in both the honeymoon stage and the precontemplation stage, the situation is especially dangerous.

There are other barriers to receiving DV services longitudinally. The location of the services at a hospital may deter some DV victims from seeking services. Some fear that the doctors and nurses may break confidentiality due to mandated laws regarding the reporting of DV to the Department of Health and Human Services. In addition, many DV victims identified at SCHC are mothers, as seen through the demographic characteristics of this study's subjects. Mothers face the additional responsibilities of childcare that compete with any DV problems. For example, if a mother plans to leave her abusive partner, it may mean the withdrawal of financial support and housing for the child as well as for the mother. On the contrary, some motivators for longitudinal use of DV services may include court-mandated counseling by child protective services and financial incentives (e.g. victim's compensation assistance).

The low use of services longitudinally may be also reflective of the success of the program. It is likely that some DV victims did not need services longitudinally due to more simplified DV situations. For example, some DV victims may only need minimal encouragement to make positive changes in their relationships. Additionally, it is possible that many identified DV victims are seeking help outside of CAMP. Part of CAMP's services includes the provision of resources, such as the phone number for the Philadelphia Domestic

Violence Hotline. The provision of resources in one contact may lead DV victims to seek DV services elsewhere. Further investigation may determine how the low use of services longitudinally reflects how the needs of DV victims are met by CAMP.

Not all the original plans for this study were fulfilled. The researchers of this study had planned to examine the impact of DV services on the safety and stability of DV victims, and the association between the utilization of DV services and the safety of DV victims. However, after the retrieval of the extant data, we found that changes in safety and stability outcomes could not be assessed. The database at LSH in which the data are stored overrides pre-existing entries on safety and stability markers with the most recent ones. For example, if a safety marker, such as safety to call, changes over the period in which the subject receives services, this change will not be reflected in the data, since the most recent entry on the safety marker overrides any past entries. In addition, the safety of phone calls may not be an accurate reflection of the subject's overall safety, especially since the popularity of cell phones has decreased the shared use of telephones. Future development of valid and reliable safety variables will help determine the true changes in safety for the DV victims.

Furthermore, there were low response rates for stability variables. Marital status had a 49.5% response rate, and economic variables had 6% or less response rates. DV victims are a vulnerable population. When the DV counselor (or other staff) interacts with the DV victim, the immediate safety needs to the DV victim are imperative compared to the evaluation needs of the program. Therefore, those variables (e.g. marital and economic) which are not directly relevant to the safety needs of the victim may not be documented by the DV counselor. Training of CAMP staff on how to collect these variables during their interactions with DV victims may increase the response rates of stability variables in the future.

Moreover, data collection of types of DV services utilized is difficult. For this reason, we were not able to analyze them in this study. In the database, types of services utilized were entered in free form under the category 'Notes.' The DV counselor described, in her own words, the services offered to subjects. In analyzing the data, it was difficult for the researchers to interpret and categorize the results. In addition to the organization, the 'Notes' were often written in a cryptic manner due to legal considerations. This is due to the danger in collecting data that could be used in the future by lawyers against DV victims. In fact, the Pennsylvania Coalition Against Domestic Violence (PCADV) prohibits participating organizations from documenting discoverable information that could be used against DV victims in a court of law. For example, mental health outcomes, like depression, could be used to indicate that a DV victim is "unfit" to care for a child. Since CAMP receives funding from PCADV, it is restricted in what information it can collect from DV victims. Therefore, the complexity of how the data on types of services were entered into the database, which occurred due to legal concerns, prevented their inclusion in this study. This legal restriction may prevent successful cases, which are known to the DV counselor, from being observed by others. Future studies may aid in determining how to develop better document the utilization of DV services.

The results of this study are useful in understanding the population served by CAMP. First, the results allowed CAMP to tailor their services appropriately to their participants. The need to educate the community about DV has become apparent, as many identified DV victims do not view their situations as dangerous, and thus, do not seek further services. In fact, the current DV counselor noticed this during her group educational sessions on DV as part of community outreach to parents at a local middle school. She had a captive audience that wanted to learn even more about DV than offered. Moreover, support groups for parents may prove

successful in encouraging DV victims to seek services, since parents deal with different issues regarding DV than do DV victims without dependents. In order to provide identified DV victims with appropriate services, an increase in resources for DV victims in Philadelphia is necessary. For example, there is only one emergency shelter for DV victims living in Philadelphia. This shelter, which is almost always full, has only 100 beds including cribs (Women, 2010). The results of this study may help staff advocate for the necessary funds to improve the livelihood of DV victims.

Secondly, the results will help guide future outcomes-based evaluation of CAMP. Further investigation is needed to explain why many DV victims do not seek services longitudinally and why there are so many single DV victims. Knowledge of the DV victims' demographic characteristics, their little use of DV services longitudinally, and any strengths and weaknesses in data collection and organization methods will help CAMP staff develop more rigorous evaluation in the future. In return, this will allow researchers to determine the effectiveness of health care-based DV programs in producing positive outcomes for DV victims.

Moreover, literature on the health and safety outcomes of participants of DV programs is scarce. Most evaluation studies on DV programs focus on self-reported knowledge, attitudes, and behaviors around screening practices. There are no studies in the literature that evaluated the outcomes of participants of DV programs within pediatric health care settings. The results of this study can profile to other health care settings what to expect when implementing similar DV programs and corresponding evaluation. These results also provide a programmatic framework that predicts low longitudinal utilization of services and difficulty in collecting data. In addition, more resources are needed to meet the needs of DV victims. If the longitudinal utilization of services increases to 100%, the programs will need more staff and funds to be sustained.

There are several other strengths to this study. SCHC's CAMP is unique in its use of an on-site DV counselor. Only one other pediatric health care setting in the U.S. has an on-site DV counselor (personal communication, Mario Cruz, December 10, 2010; O'Campo, et al., 2011). One individual DV counselor at SCHC worked with all the subjects of the study. In addition, all data were collected within the same site and with the same data collection methods. This allowed for consistency of data collection and data entry and increased internal reliability of results. Nonetheless, the use of one site also reduces the generalizability of the results. This study holds strength in its large sample size (637 subjects) and length of data collection (five years). This is especially important since much time and detail are needed in order to show changes in the situations of DV victims. Lastly, the DV counselor was unlikely to be biased in the data collection, since she had no knowledge of future studies to be performed on the data. In this regard, the study was similar to a blind study in that the data were analyzed by someone entirely unrelated to the data collection process and without any identifiers.

On the other hand, there are several limitations in the method of data collection and storage. First, this study has limited generalizability. The demographic characteristics of subjects are reflective of SCHC's location and source of subjects. The study excludes those unwilling to disclose their DV victimization. In addition, not all medical facilities can have on-site DV counselor like SCHC. Another limitation to this study is in the amount of missing data. Several variables (employment status, educational level, source of income, and housing status) could not be used due to their low response rate. Improving the quality of the data collection methods may improve response rates. One improvement was the creation by LSH's BDVP of a record form with specific close-ended questions for CAMP staff to ask of the participants (see Appendix). Unfortunately, most of the data collected for this study covered preceding years.

Also, the form is not complete. For example, it is missing the listing of "legal counseling" as a type of service offered by CAMP. In addition to the form, CAMP could benefit from the training of its staff in methods of collecting useful data during counseling sessions with participants. This is especially difficult, since many participants are in crisis or near-crisis situations, and collecting study data could interfere with services. Data on variables such as employment status was often not directly applicable to the DV victims' situations and, thus, not collected. Therefore, future evaluation that assesses the health and safety outcomes of DV-affected families will be ever more useful.

Conclusions and Recommendations

This study described the demographic characteristics, the most recent safety markers, and the service utilization by SCHC's CAMP's subjects during the period between October 1, 2005 and October 1, 2010. Based on our knowledge, no prior study of its kind has evaluated the health and safety outcomes of participants of a DV program. This study's results will therefore be useful in tailoring future DV services to participants as well as an appropriate program assessment and evaluation. Findings may also provide other research teams what to expect as they develop DV programs in other healthcare settings. The study gains its strength in its uniqueness within the field of DV, its consistency in having had only one DV counselor, site, and data collection methods, its large sample size, its five-year span of data collection, and its limited bias. Limitations include the inability to track changes over time, its limited generalizability, the number of missing entries, and the organization in data collection of services utilized.

There are several recommendations that warrant inclusion. First, further investigation will explain why low utilizers use so few CAMP services, why high utilizers use many services,

why there are so many single DV victims, and why so few DV victims are identified in comparison to the number of patients seen at SCHC. Approximately 80,000 families seek medical care by SCHC every year (Mario Cruz, personal communication, May 7, 2011). When considering how many DV victims were identified at SCHC over the past 5 years (686 DV victims) and how many women are statistically abused (25%), this number seems rather low. Creating a written form of the DV screening methods in different languages may increase the number of DV victims identified at SCHC. Moreover, it may be useful to compare the outcomes derived from CAMP, which actively seeks DV victims through routine screening, with the outcomes of LSH, which passively seeks DV victims through flyers and its website. In this comparison, it would be useful to note what types of abuse (emotional, sexual, economic, and physical) the DV victims are experiencing. Many DV victims do not realize that emotional abuse is a form of DV and, thus, do not seek help when experiencing it. Future facilitation of focus groups may reveal, in some measure, answers to these investigative questions.

There are several ways in which CAMP could enhance their DV services. Education of the communities, especially parents, served by SCHC on DV would increase their level of awareness. There appears to be little awareness of DV amongst community members living near SCHC, especially when it is not physical or sexual abuse. Increasing awareness may encourage those experiencing DV to seek help and may prevent relationships from turning into DV. Moreover, DV support groups for parents may encourage an increase in the number of DV victims seeking help. Since parents have competing childcare responsibilities, they have increasing difficulty in seeking help and making healthier choices in their relationships. Parents experiencing DV may find encouragement from each other in dealing with their DV situations. Lastly, there is a great need for additional DV resources. The creation of more DV shelters in

Philadelphia is crucial for the safety of DV victims. Increased funding will enable DV programs like CAMP to continue serving DV victims.

The next recommended step relative to the evaluation of CAMP will be the development of a survey tool to assess the outcomes of its participants. The survey tool may improve the organization of data collection, allow staff to track changes over time, and assess health and safety outcomes of participants. These steps will allow for more rigorous evaluation of CAMP, and provide more substantial evidence for recommendation of DV screening across medical facilities. Thus, the results of this study contribute to the advancement of and advocacy on behalf of DV services in health care settings.

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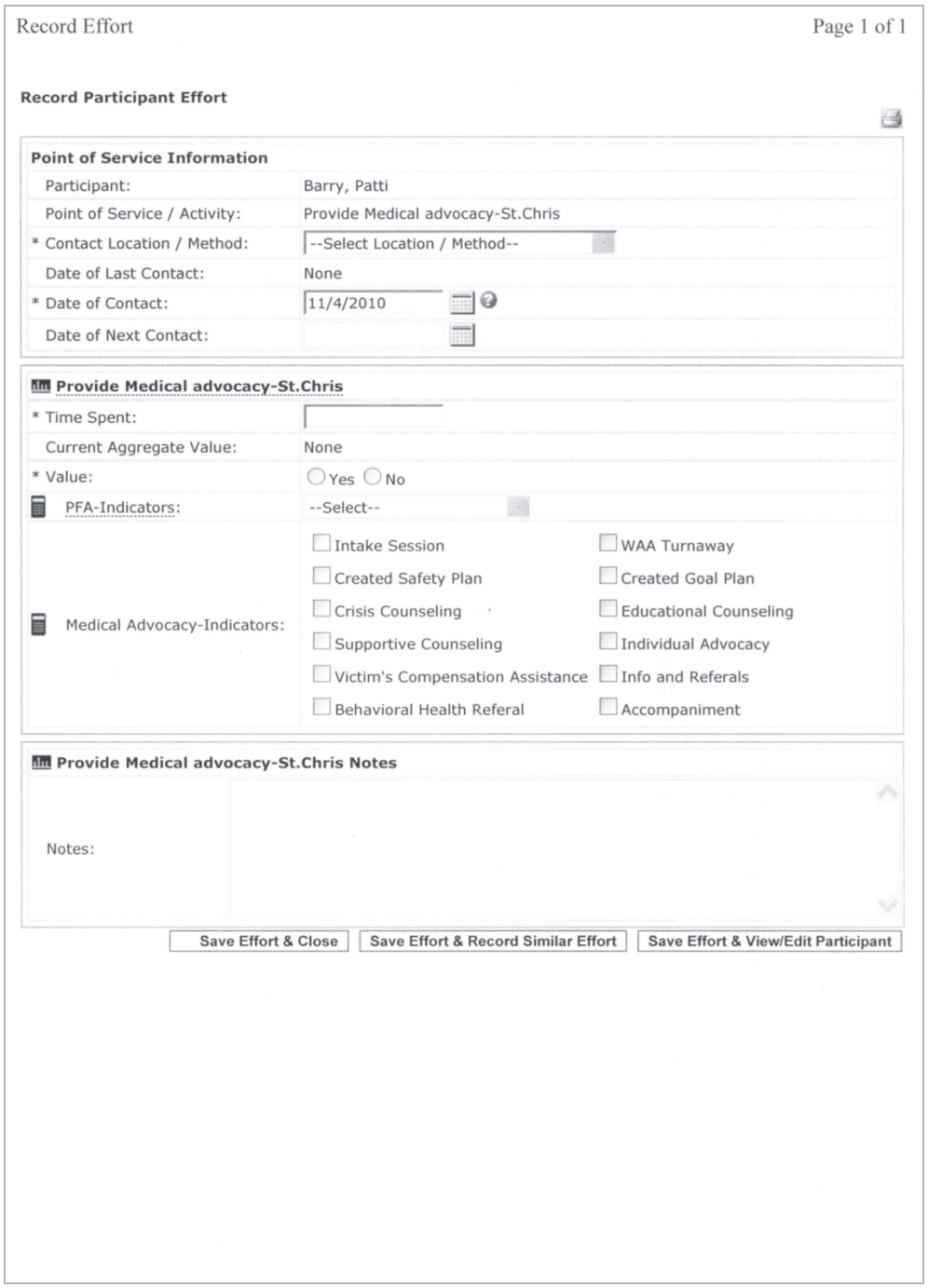
APPENDIX

APPENDIX

Data Collection Form



Record Effort — Page 1 of 1

Record Participant Effort

Point of Service Information

Participant:	Barry, Patti
Point of Service / Activity:	Provide Medical advocacy-St.Chris
* Contact Location / Method:	--Select Location / Method--
Date of Last Contact:	None
* Date of Contact:	11/4/2010
Date of Next Contact:	

Provide Medical advocacy-St.Chris

* Time Spent:	
Current Aggregate Value:	None
* Value:	Yes No
PFA-Indicators:	--Select--
Medical Advocacy-Indicators:	Intake Session; WAA Turnaway; Created Safety Plan; Created Goal Plan; Crisis Counseling; Educational Counseling; Supportive Counseling; Individual Advocacy; Victim's Compensation Assistance; Info and Referals; Behavioral Health Referal; Accompaniment

Provide Medical advocacy-St.Chris Notes

Notes:

Save Effort & Close | Save Effort & Record Similar Effort | Save Effort & View/Edit Participant

Add Participant:

Participant Information

Prefix:	--Select--
***First Name:**	
Middle Initial:	
***Last Name:**	
Suffix:	--Select--
Address 1:	
Address 2:	
Zip Code:	-
Email:	
Home Phone:	
Work Phone:	**Ext.**
Cell Phone:	
Pager:	
Referral Source:	--Select--
Participant Funding:	--Select--
SSN:	
Case Number:	
DOB:	-Month- -Day- -Year-
Gender (USE THIS):	--Select--
Race:	--Select--
Marital Status (USE THIS):	--Select--
Differently-abled (physical disability):	○ Yes/True ○ No/False
How did you learn about Lutheran Settlement House?:	☐ Friend/Family ☐ Counselor/Case worker ☐ Through other program ☐ Newspaper ☐ Internet/Website ☐ Advertisement(Septa) ☐ Community Outreach ☐ Presentation by LSH staff ☐ Other ☐ OESS
If other please define?:	
Current Employment Status:	--Select--
Source of Income:	
Current Housing Status:	--Select--

Number of Dependents:	
Emergency Contact and Phone:	
Other Emergency Contact and Phone:	
Last Grade Attended:	--Select--
Last Grade Completed:	--Select--
Participant Type::	--Select--
Language:	--Select--
Is it safe to call?:	--Select--
Is it safe to leave a message?:	--Select--
Is it safe/use discretion if someone else answers?:	--Select--
Notes::	
Do you have caller ID?:	--Select--
Is it safe for the agency number to appear?:	--Select--
Do you have anonymous call rejection?:	--Select--
Call back notes::	

Emergency Custody Contact Information-Shiela Brown

Names of Children and DOB:	
1. Caregiver Name::	
Relationship::	
Address::	
Phone::	
Other Phone::	
2. Caregiver Name::	
Relationship::	
Address::	

Phone::	
Other Phone:	
Hospital Referral Source:	--Select--
Primary Counselor:	
DHS involvement:	--Select--
Program Enrollment Information	
Enroll in Program: BDVP	☑
***Program Start Date:**	Nov 4 2010
Projected End Date:	-Month- -Day- -Year- (optional)

SUBMIT